VZCZCXRO6377
RR RUEHPT
DE RUEHBY #0464/01 1372221
ZNR UUUUU ZZH
R 172221Z MAY 09
FM AMEMBASSY CANBERRA
TO RUEHC/SECSTATE WASHDC 1498
INFO RUCPDOC/DEPT OF COMMERCE WASHINGTON DC
RUEATRS/DEPT OF TREASURY WASHINGTON DC
RUEHDN/AMCONSUL SYDNEY 4565
RUEHBN/AMCONSUL MELBOURNE 6342
RUEHPT/AMCONSUL PERTH 4605
RUEHWL/AMEMBASSY WELLINGTON 5781
RHEHAAA/NATIONAL SECURITY COUNCIL WASHINGTON DC

UNCLAS SECTION 01 OF 06 CANBERRA 000464

SENSITIVE
SIPDIS

STATE FOR EEB, OES, AND EAP/ANZ; STATE PLEASE PASS HHS

TAGS: ECON PGOV SOCI AS
SUBJECT: Australian Health Care - An Overview

Summary

¶1. (SBU) Australia's mixed public and private health care system achieves some of the best health outcomes in the OECD despite healthcare spending comprising less than 10% of GDP. Australia is second in the OECD for life expectancy at birth and 16th in percentage of GDP spent on healthcare. Australia's Medicare system provides universal access to those without private health insurance while using rebates and tax penalties to encourage as many people as possible to purchase private health insurance. Most physicians are self-employed or work for private hospitals or clinics. Private hospitals and insurance play a key role in the overall system, with 44% of the population covered by private health insurance. About two-thirds of total hospital beds are provided by the public system, with the balance provided by private hospitals. With state governments responsible for delivering public health services but dependent on Commonwealth funding to cover costs, the public health system has been an issue in recent state elections. The system is imperfect, with often lengthy delays for elective medical procedures, significant problems for aboriginal and rural health access, and rising costs. The current system is largely popular with patients and practitioners, and generally delivers on the stated social goal of universal access and good outcomes at a comparatively low cost. End summary.

AUSTRALIAN MEDICAL SYSTEM - A BRIEF OUTLINE

MEDICARE AND PHARMACEUTICAL DRUGS

¶2. (U) The main pillar of Australia's health care system is the universal health insurance system funded by Australia's Federal government, first introduced in 1974 and modified several times since. Now known as Medicare, this program provides guaranteed access at low costs to basic health care for all Australian residents. Medicare subsidizes payments for services provided by doctors and other health professionals. Though funded in large part by the Federal government, the system is run by Australia's eight state and territory governments, which fund and operate public hospitals that provide services that are covered by Medicare. With the exception of some employed by public hospitals or state universities, doctors are not salaried employees on a government payroll. They are either self-employed or members of a medical practice. Medical providers are free to charge what they want for their services, although reimbursement from the Federal government is capped based on the Medicare Benefits Schedule (MBS).

¶3. (U) According to analysis by the Congressional Research Service of 2006 OECD Health Data, Australian specialists earn an average US$247,000/year (PPP basis), 7.6 times better than per capita GDP and double the OECD average of US$113,000. General practitioners (GPs) averaged US$91,000 (2.8 times per capita GDP, slightly above

the OECD average US$83,000), and nurses US$48,000 (OECD average US$33,000). In 2005-06, the Australian health sector employed 753,000 people, 7% of the civilian work force.

¶4. (U) Medicare provides no dental coverage (a debate is underway whether dental care should be covered); similarly, ambulance services are not part of the system and are paid for by the individual or their private insurance. Low income people are Qindividual or their private insurance. Low income people are eligible for some subsidies for these services, which falls outside of Medicare.

¶5. (U) Fees for medical services provided by private practitioners are established by the federal Department of Health and Ageing, in conjunction with medical profession experts from both the public and private sectors. These "schedule fees" serve as a floor for private physicians and hospitals, who may charge whatever they wish for their services. For patients admitted to hospitals, the Medicare benefit (i.e., what the GOA will cover) is equal to 75% of the schedule fee; for nonhospital services, Medicare pays up to 100% of the schedule fee for consultations with General Practitioners (GP) and up to 85% for services from specialists. The patient pays the difference ("gap") between the benefit paid and the schedule fee, to a maximum of A$65.20 (indexed annually), and pay any costs above the schedule fee. In addition, all families have a cap of around A$365/year (US$274 based on 5/15/09 exchange rate of A$1.00 = US$.76) for "gap" payments for out of hospital services, after which they are reimbursed 100% of the schedule fee (but still not for anything above the schedule fee). Some are eligible for other benefits for medical fees, and a 20% tax rebate on expenses over A$1500 (US$1125) can be claimed on medical expenditure in certain

categories including Medicare payable items.

¶6. (SBU) Australia's health care system has evolved into its current form over the past 60 years. The Pharmaceutical Benefits Scheme (PBS) is the oldest element of the system. PBS was introduced in 1948 to provide a limited range of "life-saving" medicines; it is now the price setter for all prescription medicines in Australia. Prescriptions are filled by pharmacies which purchase their drugs from providers at a wholesale price established by the PBS and charge customers a set price negotiated with the PBS, with a relatively low cost (co-payment) to the patient that is set by PBS. For 2005-06 the average patient cost per prescription was A$6.70 (US$5, does not include non-PBS prescriptions; costs are cheaper for some categories of patient); PBS picked up A$32.10 per prescription. As of December 2007, PBS covered 819 drug substances (generic drugs), available in 2749 forms and strengths (items) and marketed as 3481 products (brands). PBS is very popular with the public and medical practitioners, although not with pharmaceutical companies, who complain about PBS's squeezing costs at their expense.

PRIVATE SECTOR THRIVES

¶7. (SBU) The private sector is a key component of the Australian medical system - not only do private hospitals, pharmacies, and health insurance funds exist, they are explicitly encouraged and subsidized by the Federal government. As Angela Pratt, chief of staff to Health Minister Nicola Roxon, and others have told us, the competitive tension between public and private hospitals and providers is an important part of the system. And the presence of the private sector reduces the burden on public hospitals.

PRIVATE INSURANCE

¶8. (U) The system deliberately encourages Australians to purchase private insurance if possible. Private health insurance is readily available in Australia, but must meet certain conditions. Since 1983, insurers have been required to offer health insurance to all on a community-rated basis which prevents them from charging more (or refusing coverage) based on pre-existing conditions, age, or other factors. Policies are available that exclude certain medical developments such as care related to pregnancies and childbirth, or

certain medical conditions, making the policy cheaper and leaving the patient to rely on Medicare for those issues should they arise. Further, they are restricted by law to insuring only in-hospital procedures. Insurance is bought by individuals directly. Employers do not pay insurance premiums for employees - they have no direct role in funding health. As a result, insurance is fully portable and is not linked to specific employment. Individuals can also choose to purchase more expensive insurance policies that offer more extensive coverage. Overall insurance costs are contained by the strong influence of the Medicare system's fee structure.

¶9. (SBU) As Australian Health Insurance Association CEO Michael Armitage told embassy, while these restrictions have helped keep private insurance relatively cheap, it has limited their ability to innovate or expand into new areas. Still, private insurers pay for an estimated 11% of medical costs in Australia, including about 55% of all operations. Criticism that private health care has created additional demand rather than accommodating overflow from the public Qadditional demand rather than accommodating overflow from the public sector is unfair, according to Armitage, who pointed out that private insurers pay for many Medicare-covered procedures such as joint replacements and chemotherapy.

¶10. (U) Private health insurance covers procedures done in private hospitals, or done in public hospitals by private physicians. Private hospitals, which include for-profit operations, offer a choice of provider, shorter waits for certain procedures, and generally better amenities for both patients and doctors when compared to the comparatively spartan public hospitals. In any case, the public and private health systems are quite interdependent. They often share the same workforce and facilities, and there is frequent coordination between public and private health providers in treating a patient.

¶11. (U) The private sector is also subsidized by the government. At one point in the 1990s, the share of Australians holding private insurance had dipped to near 30%. In response, the GOA introduced a rebate, returning 30% of private insurance premiums to the purchaser - a A$3 billion (US$2.25 bn) per year subsidy for insurers. With that carrot, the GOA wields two sticks; a medical levy surcharge of 1% of income if an individual earns over A$70,000 (US$53,000) and does not carry private insurance, and a 2% surcharge on private health insurance premiums for every year past age 30 that a person

does not own private insurance, up to a maximum 60% surcharge. (In the budget issued May 12, the GOA proposes to phase out the rebate for high income earners, and increase the medical levy surcharge for the same high income people to 1.5%. Health Minister Nicola Roxon says GOA modeling shows this would have a negligible impact on the purchase of private health insurance.) With these policies, insurance ownership has rebounded and around 44% of all Australians now own private hospital insurance. Nearly half of the insured population has gross household incomes under A$70,000, which means that nearly 4.3 million holding private insurance earn less than the average income.

¶12. (U) The government reaps benefits from subsidizing the private insurance sector. Private insurance directly supports private hospitals and eases the burden on public hospitals. It gives consumers greater choice, reduces government costs, and allows government spending to flow to those with the greatest need. Costs of private insurance vary significantly depending on the level of coverage and the state of residence, making national comparisons difficult. As an example, a basic policy for two adults plus dependents in New South Wales (Australia's most populous state) covering treatment in public hospitals only can be purchased for as little as A$808/year (US$606). A policy for the same group (two adults plus dependents) with access to "top" private hospitals and "comprehensive" coverage would run A$4575/year (US$3440); both figures are actual costs to consumers after the 30% rebate from the government.

¶13. (SBU) The hybrid public/healthcare system is broadly supported in Australia, although some argue that the A$3 billion/year subsidizing private health insurance should be directed instead at

improving the public health system. Anecdotally, most Australians believe that if you can afford insurance, you should buy it. But as Francis Sullivan, Secretary General of the Australian Medical Association, described it in a conversation with embassy, most Australians are comfortable with less choice in exchange for guaranteed access to essential medical services.

HOSPITALS

¶14. (U) Hospitals account for more than one-third of recurrent health expenditure in Australia, and are the single biggest cost for the states' and territories' medical budgets; this also makes health care a big campaign issue in state elections. Patients generally access public hospitals via a referral from a general practitioner (GP), or through emergency departments. Public hospital emergency and outpatient services are free, as is inpatient treatment for public (Medicare) patients. People admitted to a public hospital can choose to be treated there as either a public or private patient, or can choose to be admitted directly to a private hospital. Private patients treated in a private hospital can choose their specialist, but charges apply for all of the hospital's services such as accommodation and surgical supplies. Medicare subsidizes the fees charged by doctors in both public and private hospitals, and private health insurance contributes towards medical fees and hospital costs.

¶15. (U) In 2005-06 Australia had 1302 hospitals and 80,828 beds. Of those, 755 were public hospitals providing 54,601 beds. Public Qthose, 755 were public hospitals providing 54,601 beds. Public hospitals accounted for 16,993 patient days, private hospitals 7473.

GENERAL PRACTITIONERS

¶16. (U) General practitioners (GPs), whether private or public employees, play a key role in the Australian system. They are usually the first point of contact for patients, and serve as the primary care provider. Referrals to specialists and other health workers and for medical tests usually come through GPs. The results of tests and visits to specialists are then passed back to the GP, who is responsible for coordinating the ongoing care for the patient. The Australian Medical Association describes GPs as "a gatekeeper to health services," and stresses that GPs have the right to refuse a request from a patient for a referral the GP feels is inappropriate. However, some patients do "self-refer" to specialists without going through a GP (in Australia, "general practitioner" is a specialty in its own right, with its own specific training). "Self-referring" is discouraged, including by many specialists who will only see patients armed with a GP's referral letter. This can be a serious impediment in urgent cases. It is also penalized financially; a self-referring patient will get a lower benefit from the government for a given procedure.

WHO PAYS FOR IT, AND HOW MUCH DOES IT COST?

¶17. (U) In FY 2005-06 Australia spent A$86.9 billion (US$65.2 bn), then about 9.0% of GDP, on health to cover a population that is currently 21 million. Spending on health has crept up steadily. FY2005-06 spending itself was about 45% more per person than ten years earlier, and now this spending is an estimated 9.8% of GDP. Of the total spent on health care, the GOA expenditure was 43%, and states and territories paid 25% (this total of 68% compares with an OECD average of 73% of health spending being paid by public sources). Private insurers covered another 7% (according to GOA figures that take into account the A$3 billion/year subsidy on health insurance premiums), and direct payments by individuals comprised 17%. Federal money was spent mostly on medical services (A$12 billion), public hospital services (A$10 billion), and pharmaceuticals (A$6 billion). States/territories (and some localities) spent A$22 billion in FY2005-06, of which A$12 billion was for hospital services. Federal funding for healthcare is sourced in part by the Medicare levy of 1.5% of taxable income, which generated A$6.5 billion in FY2005-06. General revenues cover

the majority of federal funding for health. (See table at end of cable for comparisons with OECD countries for health care spending.)

¶18. (U) Over half of the 32% paid by non-government sources was from private individuals, including where patients paid for the entirety of a good or service, and instances where costs were split with private insurers or the GOA. Of the A$28 billion of out-of-pocket costs, nearly A$8 billion was for dental care. Medications were split between the GOA (A$6.1 billion) and customers (A$5.3 billion).

¶19. (U) The private sector is leading the way on capital health expenditures. In 2005-06 non-government spending on medical infrastructure (total A$5.2 billion) was nearly 60%; the states spent 37% and the GOA only 3.5%.

HOW IS IT WORKING

THE GOOD NEWS

¶20. (U) For the share of GDP spent on health care, Australia does well in the OECD health data. Australia's 9.0% (2005-06 GOA figure, now estimated 9.8%) of GDP spent on medical care and per capita spending were close to the OECD average. According to OECD data, per capita health administration and insurance costs for Australians in 2004 was US$86 (PPP basis), compared to US$65 in the United States, US$238 in France, and the OECD average of US$104. (The OECD does not compile data comparing costs for specific procedures across economies.)

¶21. (U) Australia now has the second highest life expectancy (81.4 years) among OECD members, behind only Japan. Death rates among children and young people have dropped by over 50% over the past two decades - infant mortality was below OECD average. Smoking rates in adults have dropped from 35% to 15%, in part due to public health campaigns stressing its health risks. Death rates from conditions like cancer, heart disease, strokes, injury, and asthma are declining. More people are surviving heart attacks, which are growing less common - although coronary heart disease remains Australia's top cause of death. The number of people with disabilities is rising, reflecting in part improved survival rates from injuries or conditions that would have killed earlier Qfrom injuries or conditions that would have killed earlier generations. (See table at end of cable for comparisons with OECD countries on life expectancy.)

¶22. (U) Although a small country, Australia has a vigorous medical research sector. A medical researcher at Australian National University told us that Australia, with under 1% of global population, accounts for 4% of medical research publications worldwide. The Federal government gives grants of about A$1 billion per year, and the states and territories are competing to be centers of medical research, kicking in their own funds and incentives. Two Australian medical researchers have won Nobel Prizes in recent years, and the new cervical cancer vaccine was developed in Australia. However, as in other sectors, Australia lags in commercializing its medical discoveries. They tend to be licensed to overseas corporations rather than developed locally, in part because of comparatively little venture capital and a small domestic market.

THE BAD NEWS

¶23. (SBU) There are problems. The worst is the abysmal situation of indigenous Australians - aborigines and Torres Straits Islanders. Life expectancy for them is some 17 years lower than other Australians, despite per capita medical spending that is 17% higher. But this is a subset of the overall problems of indigenous Australians rather than one specific to the health care system, and is beyond the scope of this report.

¶24. (U) Part of their problem is shared by many other Australians -

the tyranny of distance. Australia is the size of the continental United States, but has a population of 21 million. A large majority of those 21 million live in or near a few metropolitan areas - Sydney, Melbourne, Brisbane, Adelaide, and Perth. "Country" Australians find it very difficult to attract medical professionals - doctors, nurses, pharmacists, dentists, technicians - to their isolated towns and villages; the GOA has made more proposals to encourage medical professionals to practice in these areas in its May 12 budget. For many Australians, a visit to the doctor means a drive of over a hundred miles - and visiting a specialist means flying to one of the big cities. Even to give birth, now many rural women must fly to a distant city where there is a hospital with a birthing center. Emergency medical services in the outback are often provided by the iconic Royal Flying Doctor Service or similar air ambulance services. Even moderately large towns like Australia's capital city Canberra (population 350,000) have a hard time keeping higher-end specialists due to a small population base and lack of amenities at the hospitals (one health expert told us wryly that hospitals are competing to attract doctors not patients), and air ambulance flights to Sydney for treatment are common.

¶25. (U) The size of Australia has defeated some efforts to introduce managed care. There was a trial done in the 1990s to see whether it was possible through bundled care to improve outcomes at no additional cost for the 20% of the population that consume 80% of medical spending. The conclusion is that it would be difficult to make it work in Australia because of the small size and geographic distribution of the population. This also contributes to Australia's significant interest in telemedicine.

¶26. (U) Australia is proud to be #2 in the global standings for life expectancy. Unfortunately, by some measures they have surpassed the United States and Britain to take the #1 spot in the global obesity table - with obvious concerns for the impact on health. Similarly, although smoking has dropped rapidly thanks in large part to public campaigns about the perils of tobacco, alcohol consumption remains high. Generally, Australia has the same medical problems that come with prosperity as most other wealthy societies. And like other Western countries, Australia has an aging population, so it faces challenges related to that and to chronic disease management.

¶27. (U) The public health sector has an explicit trade-off. Everyone is guaranteed cheap and reasonably good treatment through the public system. But it is very common to have to wait for consultations with a specialist or elective surgery in a public hospital. For example, in 2005-06 the median wait for an elective coronary artery bypass graft in a public hospital was 20 days; for Qcoronary artery bypass graft in a public hospital was 20 days; for total knee replacement, nearly 180 days.

¶28. (U) Several experts noted to us that as in other countries, Australia does not do well on prevention. Medicare is designed around episodic treatments - fees for treating a patient, performing surgery, etc. There is little incentive or funding available for preventative measures; this is the subject for a task force set up by the Rudd Government that is due to report back in mid-2009.

¶29. (SBU) Comment: Our government and private sector contacts all agreed that the current system for Australia, despite its imperfections and increasing costs, is working well. Australians generally enjoy good health (which admittedly includes other factors beyond the medical system such as access to clean water), costs are not too high, and Medicare and the PBS are genuinely popular. Even most physicians, who strongly opposed the imposition of a universal health program in 1974, now support the current system. Nobody loses access to medical care when they become unemployed; nobody is refused insurance or even employment due to pre-existing medical conditions. In addition to delivering good quality medical care to all Australians at reasonable costs, and allowing for private insurance and private hospitals for those able and willing to pay more, the current system also appeals to the Australian sense of fairness. Those who can afford to pay more and get more. But there is a basic level of medical care made available for all Australians, regardless of income, insurance, or employment status. End comment.

HEALTH SPENDING (OECD, ranked by per capita income)

Country	income per capita (US$, PPP)	health spending share %GDP (OECD rank)	per capita health care expenditure US$ (OECD rank)
¶3. United States	43.8	15.3 (1)	8711 (1)
¶6. Canada	36.8	10.0 (8)	3678 (5)
¶10. AUSTRALIA	35.5	8.8 (16)	2999 (15)
¶12. Sweden	34.9	9.2 (12)	3202 (13)
¶14. United Kingdom	33.0	8.4 (18)	2760 (16)
¶16. Germany	32.0	10.6 (4)	3371 (10)
¶17. Japan	31.9	8.2 (21)	2474 (20)
All OECD	31.5	8.9	2824
¶18. France	31.0	11.1 (3)	3449 (8)
¶20. Italy	28.9	9.0 (15)	2514 (18)
¶22. New Zealand	25.9	9.3 (10)	2448 (22)

LIFE EXPECTANCY AT BIRTH (OECD ranking, ranked by life expectancy, 2005)

Country	life expectancy at birth (years)	infant mortality - deaths per 1000 live births (OECD rank)
¶1. Japan	82.1	2.8 (4)
¶2. AUSTRALIA	81.4	5.0 (20)
¶5. Italy	80.9	4.7 (18)
¶6. Sweden	80.9	2.4 (2)
¶7. France	80.4	3.6 (9)
¶8. Canada	80.4	5.3 (23)
¶11. New Zealand	79.6	5.1 (21)
¶16. Germany	79.3	3.9 (12)
¶19. United Kingdom	78.9	5.1 (21)
¶24. United States	77.9	6.8 (27)

CLUNE